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CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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CHAPTER II PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating provider is an institution, facility, agency, person, partnership, corporation, or association that is certified to provide home health services by the Virginia Department of Health (VDH), or a provider that has been granted Deemed Status by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS). Out-of-state home health agencies may apply for Virginia Medicaid enrollment if they are Medicare-certified or licensed by the state in which they operate.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. All providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment and Certification Unit; an original signature of the individual provider is required. An agreement for a group practice, hospital, or other agency or institution must be signed by the authorized agent of the provider. DMAS must receive prior written notification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists. A copy of the home health care provider agreement is included in the Exhibits section at the end of this chapter.

Upon receipt of the above information, a provider number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Please read the entire manual before signing the agreement, and keep it available for reference and review during continuing participation. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, the provider must request a participation agreement by writing, calling, or faxing the request to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Note: Certification by the Virginia Department of Health, does not constitute automatic

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enrollment as a Medicaid Home Health provider.

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Medical Assistance Program must perform the following activities, as well as any other activities specified by DMAS:

- Immediately notify First Health Services Provider Enrollment (FHS/PEU), in writing, of any change in the information that the provider previously submitted to FHS/PEU.
- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required service(s) and participating in the Medicaid Program at the time the service was performed.
- Ensure the recipient's freedom to reject medical care and treatment.
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.
- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public.
- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered.

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For example, if a third party payer reimburses \$5.00 of an \$8.00 charge, and Medicaid's allowance is \$5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the \$3.00 difference. A provider may not charge DMAS or a recipient for missed or broken appointments.

- Accept assignment of Medicare benefits for eligible Medicaid recipients.
- Use Program-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.

In general, such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section titled "Documentation of Records," page 4.)

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid.
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

PARTICIPATION CONDITIONS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. The paragraphs which follow outline special participation conditions which must be agreed to by certain types of providers.

CERTIFICATION AND RECERTIFICATION

Home health services provide periodic care under the direction of a physician. Such services are provided by participating home health providers.

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The Virginia Medicaid Program is dependent upon the participation and cooperation of physicians who provide or oversee **all categories** of health care. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with excellence in medical practice and economic considerations.

Prior to the delivery of home health services, the physician must certify the patient for the prescribed treatment by completing in full a Plan of Care. Recertification is required at intervals of at least once every 62 days and is to appear on the forms as previously mentioned. For further details, see Chapter IV.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C. §794), provides that no disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, all Medicaid providers are responsible for making provision for disabled individuals in their program activities.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

DOCUMENTATION OF RECORDS

The provider agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. The following elements are a clarification of Medicaid policy regarding documentation for medical records:

- Entries must be signed and dated by the responsible licensed participating provider. Care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.
- The record must identify the patient on each page.
- All services rendered, as well as the physician signed Plan of Care, must be entered in the record.
- The record must indicate the progress toward established goals at each visit, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written for every home health visit billed to Medicaid.

UTILIZATION OF INSURANCE BENEFITS

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits is discussed below. Medicaid is the payer of last resort.

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Workers' Compensation

Items and services, to the extent that payment has been made or can reasonably be expected to be made under the workers' compensation laws of Virginia, are not reimbursable by the Virginia Medicaid Program.

Other Health Insurance

When a recipient has other health insurance such as Trigon or Medicare, Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

Liability Insurance for Accidental Injuries

The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in § 8.01-66.9 of the Virginia Code. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability, or if the recipient reports a third-party responsibility (other than those cited on the Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the Home Health provider is requested to forward the DMAS-1000 to:

Third-Party Liability Unit
Department of Medical Assistance Services
600 East Broad, Suite 1300
Richmond, Virginia 23219

A copy of this form is provided in the Exhibits section following this chapter.

ASSIGNMENT OF BENEFITS

If a Virginia Medicaid recipient is the holder of an insurance policy that assigns benefits directly to the patient, the Home Health provider must require that benefits be assigned to the Home Health provider (or the hospital if the Home Health provider is hospital-based), or refuse the request for the itemized bill that is necessary for the collection of benefits.

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TERMINATION OF PROVIDER PARTICIPATION

The participation agreement is not time-limited, and will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed licensure/certification prior to its expiration.

A participating provider may terminate his or her participation in Medicaid at any time. Thirty (30) days' written notification of voluntary termination must be made to the Director, Department of Medical Assistance Services and the First Health PEU.

DMAS may terminate a provider from participation upon thirty (30) days' written notification. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

Subsection (c) of § 32.1-325 of the Code of Virginia mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify the Program of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

REPAYMENT OF IDENTIFIED OVERPAYMENTS

Pursuant to § 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to § 32.1-313.1 of the Code of Virginia. Interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

Non-State-Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions.

The reconsideration process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have a 30 day notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§ 9-6.14:1 through 9-6.14:25 of the Code of Virginia)(the APA) and the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

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Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action such as termination or suspension of the provider agreement or denial of payment for services rendered based on utilization review decisions. State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid Program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state-operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, review by the Director of DMAS, and Secretarial review. First, the state-operated provider must submit written information to the appropriate DMAS Division specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director or his or her designee will review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director will consider any recommendation of his or her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned

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provider receives program information.

A provider may not wish to receive provider manuals or Medicaid memoranda because he or she has access to the publications as a part of a group practice. To suppress the receipt of this information, the First Health Provider Enrollment Unit requires the provider to complete the Mail Suppression Form and return it to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Upon receipt of the completed form, FH-PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

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**Commonwealth Of Virginia
Department of Medical Assistance Services
Medical Assistance Program
Home Health Participation Agreement**

If re-enrolling, enter **Medicaid** Provider Number here→ _____

Check this box if requesting new number→ ☐

This is to certify:

PAYMENT/CORRESPONDENCE ADDRESS

**PHYSICAL ADDRESS
(REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS)**

NAME

ATTENTION

ADDR LINE 1

ADDR LINE 2

CITY, STATE, ZIP

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

Enter your Medicare Provider Number here → _____

State Agency

Non-State Agency

Hospital Based

Non-Hospital Based

1. The provider is currently licensed and certified under applicable laws of this state as of _____ (Date) and has been fully certified for participation with Title XVIII (Medicare) of Public Law 89-97.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his medical or physical handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) in VMAP.
3. The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP, on request, information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General, or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered under Medicaid. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid recipient for any service provided under Medicaid is expressly prohibited and may subject the provider to federal or state prosecution.
6. The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment to the provider. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.
9. This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the program.
10. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For Provider of Services:

For First Health's use only

Director, Division of Program Operations Date

IRS Name (required)

Mail or fax one completed original agreement to:
First Health - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-7027

Original Signature of Administrator

Date

Title

____ City OR ____ County of _____

IRS Identification Number

(Area Code) Telephone Number

Medicare Carrier and Vendor Number (if applicable)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MAILING SUSPENSION REQUEST

Medicaid Provider Number: _____

Provider Name: _____

I do not wish to receive Medicaid memos, forms or manual updates under the Medicaid provider number given above because the information is available to me under Medicaid provider number

Provider Signature: _____

Date: _____

Please return this completed form to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, VA 23261-6803